EAST BAY
NATUROPATHIC CLINIC
402 Colusa Ave. • El Cerrito, CA 94530 • 510.559.3640

ADOLESCENT INTAKE

Name _____ Date of birth _____
Preferred Name _____ Age _____ Gender _____
Address _____ City, St, Zip _____
Home phone _____ Cell phone _____
Emergency Contact _____ relationship _____

Parent/ Guardian: _____ Contact:_____
Parent/ Guardian: _____ Contact:_____
Parent/Guardian: _____Contact:_____
Email address _____

Grade in School:_____Level of education _____
Live with: □parents □guardians □grandparents □siblings □other
Number of siblings and ages _____ pets _____

How did you hear about this clinic? _____
Is your family interested in receiving newsletters and updates via email? □ Y □ N

Are you currently receiving healthcare? □Y □N If yes, please list healthcare providers_____
_____
If no, what was the date of your last physical exam/healthcare _____

Please list any medical diagnoses you have received:
_____ _____ _____
_____ _____ _____

Please list ALL current prescription and over-the-counter medicines, supplements, vitamins, herbs or remedies you are taking with dose information (if needed please use back of form or attach list):
_____ _____ _____
_____ _____ _____
_____ _____ _____

Are you hypersensitive or allergic to any medications/foods/other?_____
_____
Please list all hospitalizations, surgeries (including elective), and imaging (x-rays, CAT scans, MRIs, EKGs, etc) with the approximate date:
_____ _____ _____
_____ _____ _____

Do you have any known contagious diseases at this time? □ no □ yes, what? _____
Are you currently pregnant or breast feeding at this time? □ no □ yes

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

What is the reason for today's visit?

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What are your specific goals for this visit?

What expectations do you have for me as your healthcare provider?

Please list additional health concerns or problems in order of importance:

What are your long-term goals in working with a Naturopathic Doctor?

What is your present level of commitment to address the underlying causes of your signs and symptoms?

No current commitment 0 1 2 3 4 5 6 7 8 9 10 Very committed

GENERAL HEALTH

Height _____ Weight _____
Do you engage in physical activities? □ Y □ N if yes, what do you do?_____
_____ How often?_____
Do you sleep well? □ Always □ Usually □ Rarely □ Never Do you wake rested? □ Y □ N □ Sometimes
How many hours sleep each night _____From _____pm/am to _____am/pm
Do you know your blood type ? □A □ B □ AB □ O □Rh neg. □ Rh pos. □ Don't know
Have you ever had a blood or plasma transfusion? □ Y □ N if yes, when _____
Have you ever been in a serious accident? □ Y □ N Do you have friendships? □ Y □ N
Hours per day on computer/TV? _____ Do you enjoy your school (if applicable)? □ Y □ N
Do you spend time outside? □ Y □ N Hours per week _____ Do you take vacations? □ Y □ N

What do you love to do? _____
_____
What makes you feel happy or content?_____

INTAKE

What is your typical food intake?
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
Do you: eat three meals a day most days? □ Y □ N often go on diets? □ Y □ N eat out often? □ Y □ N
Do you drink: coffee? □ Y □N black/green tea? □ Y □ N soda? □ Y □ N energy drinks? □ Y □ N
Do you: consume refined sugar? □ Y □ N consume artificial sweeteners? □ Y □ N salt your food? □ Y □ N
Are you: vegetarian? □ Y □ N vegan? □ Y □ N Do you avoid other foods? _____
Do you eat vegetables: □ Y □ N If yes, which ones? _____
What foods do you crave?_____
What foods do you dislike?_____
Do you: consume alcohol? □ Y □ N use recreational drugs? □ Y □ N
Do you use tobacco? □ Y □ N if so, what_____

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Family History (if known)
Please list any family members by relationship with known or diagnosed conditions including any of the following: cancer, diabetes, autoimmune conditions, cardiovascular issues (including stroke, heart attack, hypertension), gastrointestinal or kidney disease, addiction, or mental illness. If parents or siblings are deceased please list age of death.

_____ _____
_____ _____
_____ _____
_____ _____

Other relevant family history _____
List ethnicity if known _____

CHILDHOOD
Please list significant pediatric health information:_____
_____
Do you receive vaccines? ☐ Y ☐ N What vaccines have you received? _____
_____

REVIEW OF SYSTEMS
Please mark the following: **C** for a current condition **P** for a **significant** condition in the past
If dual symptoms are listed (ex: high/low blood pressure) please circle applicable symptom

headache	C	P	migraines	C	P	head injury	C	P
seizures	C	P	muscle weakness	C	P	loss of memory	C	P
numbness/tingling	C	P	tremors	C	P	vertigo or dizziness	C	P
loss of consciousness	C	P	paralysis	C	P	loss of balance	C	P
Eye pain or strain	C	P	double vision	C	P	impaired vision	C	P
cataracts	C	P	glaucoma	C	P	change in vision	C	P
Eye itching or burning	C	P	Eye tearing or dryness	C	P	spots in vision	C	P
ringing in ears	C	P	hearing loss	C	P	ear pain/aches	C	P
discharge from ear	C	P	loss of smell	C	P	frequent nosebleeds	C	P
hay fever/allergies	C	P	freq. head colds	C	P	sinusitis	C	P
nasal congestion	C	P	runny nose	C	P	strange odors/taste	C	P
lumps in neck	C	P	hoarseness	C	P	sore tongue or lips	C	P
freq. sore throat	C	P	snoring	C	P	teeth grinding	C	P
pain or stiff neck	C	P	excessive saliva	C	P	jaw pain/TMJ	C	P
gum problems	C	P	cavities/toothache	C	P	bad breath	C	P
cough	C	P	asthma	C	P	pneumonia	C	P
sputum	C	P	wheezing	C	P	pleurisy	C	P
coughing blood	C	P	bronchitis	C	P	difficulty breathing	C	P
emphysema	C	P	tuberculosis	C	P	pain on breathing	C	P
shortness of breath	C	P	shortness of breath while lying down	C	P	pneumonia	C	P
heart disease	C	P	palpitations	C	P	cold hands/feet	C	P
heart murmur	C	P	rheumatic fever	C	P	anemia	C	P
blood clots	C	P	ankle swelling	C	P	thrombophlebitis	C	P
phlebitis	C	P	varicose veins	C	P	easy bleeding/bruising	C	P
high/low blood pressure	C	P	chest pain /tightness	C	P	deep leg pain	C	P

Doctor's Notes:

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Review of systems cont.

change in thirst	C	P	constipation	C	P	diarrhea/loose stool	C	P
change in appetite	C	P	bloating	C	P	greater than 3 BM /day	C	P
nausea/vomiting	C	P	belching/gas	C	P	hemorrhoids	C	P
Ulcer	C	P	abdominal pain	C	P	black stool	C	P
Jaundice	C	P	heartburn	C	P	blood in stool	C	P
liver disease	C	P	pancreatitis	C	P	rectal pain or itching	C	P
trouble swallowing	C	P	gall bladder disease	C	P	change in bowel movements	C	P
frequent urination	C	P	dark urine	C	P	kidney stones	C	P
frequent UTI	C	P	cloudy urine	C	P	blood in urine	C	P
inability to hold urine	C	P	waking at night to urinate	C	P	pain or burning with urination	C	P
Arthritis	C	P	eczema or hives	C	P	psoriasis	C	P
pain in bones	C	P	change in skin color	C	P	ulcerations	C	P
broken bones	C	P	rashes	C	P	dry skin/brittle nails	C	P
dislocations/sprains	C	P	acne/boils	C	P	dandruff	C	P
Osteoporosis	C	P	itching	C	P	skin growths	C	P
muscle spasm/cramping	C	P	hair loss	C	P	growths that change in size, color, or itch	C	P
Hypothyroid	C	P	fatigue	C	P	seasonal depression	C	P
Hyperthyroid	C	P	hypoglycemia	C	P	difficulty exercising	C	P
Diabetes	C	P	excessive thirst/hunger	C	P	heat or cold intolerance	C	P
Depression	C	P	anger/temper	C	P	easily stressed	C	P
Anxiety	C	P	loneliness	C	P	considered suicide	C	P
Tension	C	P	poor concentration	C	P	attempted suicide	C	P
panic attacks	C	P	mood swings	C	P	treatment for mental emotional problems	C	P
Immunizations	C	P	night sweats	C	P	frequent illness	C	P
swollen glands	C	P	chronic infections	C	P	catch colds easily	C	P
reaction to immunizations	C	P	slow wound healing	C	P	autoimmune disorder	C	P

Doctor's Notes

REPRODUCTIVE HEALTH

Are you currently sexually active (within the past six months)? □ Y □ N sexual orientation_____

Do you use protection from sexually transmitted infections? □ Y □ N if yes, what?_____

Have you had any of the following? chlamydia gonorrhea genital warts/HPV herpes syphilis

Please complete any applicable information:

Male:

discharge/ penile sores	C	P	varicose veins in scrotum	C	P	testicular pain	C	P
testicular masses	C	P						

Do you perform regular testicular self-exams? Y N

Female:

heavy flow	C	P	vaginal discharge	C	P	yeast infections	C	P
clotting	C	P	vaginal odor	C	P	nipple discharge	C	P
endometriosis	C	P	ovarian cysts	C	P	breast pain/tenderness	C	P
bleeding between cycles	C	P	pain during intercourse	C	P			

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Female cont.

What was the age of your first menses?_____

When was the first day of your last menses?_____ How many days does your menses last?_____

How many days in between menstrual periods? _____ Are your cycles regular? □ Y □ N

Do you have PMS? □ Y □ N If yes, what are your symptoms?_____

Do you have painful menses? □ Y □ N If yes, what are the symptoms?_____

Have you had a pap smear? _____

Have you ever had an abnormal pap? □ Y □ N If yes, when? _____

Have you ever been pregnant? _____

Please list all birth control used: _____

Thank you for your time and effort in completing this comprehensive intake. We look forward to providing you with the best possible care. Please bring this form to your first visit or fax it beforehand to 510-559-3224. If there is anything else that you would like to add, please use the remainder of this page.